State Employees' Group Insurance Program

Address Change and Other Address/Addressee Information

Member Name: _____ Primary Phone#: _____

Member SSN: _____ Alternate Phone #: _____

Email Address: _____

Complete Section A if:

- You have moved or you want to change your mailing address to a P.O. Box. Note: Residential address must be kept on file and must be your actual street address.
- Your insurance information needs to be provided to an individual serving as your power of attorney, legal guardian or trustee.*

Complete Section B if:

- Your covered dependent does not reside with you.
- Your covered dependent's insurance information needs to be provided to an individual serving as the dependent's power of attorney, legal guardian or trustee.*
- Your covered dependent is in the Veteran Adult Child category.

* You must provide the appropriate supporting documentation to add a power of attorney, legal guardian or trustee to your insurance file.

SECTION A: MEMBER ADDRESS CHANGE or MEMBER'S "OTHER ADDRESSEE" INFORMATION

Complete this section if you moved, want to add a P.O. Box as your mailing address or if another person is responsible for your healthcare and needs to be informed of your insurance information.

Mailing Address of: (check one)

- ☐ Member
- ☐ Trustee
- ☐ Power of Attorney
- ☐ Legal Guardian
- ☐ In Care Of

Name _____

Street Address _____

City _____

State _____ **Zip** _____ **County** _____

If foreign address, indicate Country _____

Effective Date _____

Mail to this address: ☐ **YES** ☐ **NO**

SECTION B: DEPENDENT RESIDENTIAL or DEPENDENT'S "OTHER ADDRESSEE" INFORMATION

Complete this section if another person needs to be notified of your dependent's insurance information, if your covered dependent does not reside with you or if your dependent is covered as a Veteran Adult Child.

Dependent's Name: _____ **Dependent SSN:** _____

Mailing Address of: (check one)

- ☐ Dependent
- ☐ Custodial Parent
- ☐ Trustee
- ☐ Power of Attorney
- ☐ Legal Guardian
- ☐ Veteran Adult Child
- ☐ In Care Of

Name _____

Street Address _____

City _____

State _____ **Zip** _____ **County** _____

If foreign address, indicate Country _____

Effective Date _____

Mail to this address: ☐ **YES** ☐ **NO**

I understand that it is my responsibility to maintain correct mailing address information for dependents and/or custodial parents. I understand that I must notify my GIR of any change in address information.

Member Signature: _____ Date: _____

THIS FORM MUST BE RETURNED TO THE GROUP INSURANCE REPRESENTATIVE AT YOUR AGENCY